Appendix 4

CMS 1500 Claim Form Completion Instructions

Use the following claim form completion instructions, ***not*** the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Do not include attachments unless instructed to do so. Complete the elements listed below as appropriate.

Note: Medicaid providers should ***always*** verify recipient eligibility before providing services.

Element 1 — Program Block/Claim Sort Indicator

Enter claim sort indicator "P" in the Medicaid check box for the service billed.

Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify if male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

Enter the complete address of the recipient's place of residence.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name

Commercial insurance (private insurance coverage) must be billed prior to billing Wisconsin Medicaid, unless the service is not covered by insurance as determined by Wisconsin Medicaid.

- When the recipient has dental ("DEN") insurance only or has no commercial insurance, leave Element 9 blank.
- When the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), TriCare ("CHA"), or some other ("OTH") commercial insurance, ***and*** the service requires other health insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes ***must*** be indicated in the ***first*** box

Mother/Baby Claims

A provider may submit claims for an infant if the infant is 10 days old or less on the date of service (DOS) and the mother of the infant is a Medicaid recipient. To submit a claim for an infant using the mother's Medicaid identification number, enter the following:

Element 1a: Enter the mother's 10-digit Medicaid identification number.

Element 2: Enter the mother's last name followed by "newborn."

Element 3: Enter the ***infant's*** date of birth.

Element 4: Enter the mother's name followed by "mom" in parentheses.

Element 21: Indicate the secondary or lesser diagnosis code "M11" in fields 2, 3, or 4.

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of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID by health insurance. In Element 29 of this claim form, indicate the amount paid by health insurance to the provider or to the insured.
OI-D	DENIED by health insurance following submission of a correct and complete claim, ***or*** payment was applied towards the coinsurance and deductible. Do ***not*** use this code unless the claim was actually billed to the health insurer.
OI-Y	YES, the recipient has health insurance, but it was not billed for reasons including, but not limited to: ✓ Recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ Health insurance failed to respond to initial and follow-up claims. ✓ Benefits not assignable or cannot get assignment.

- When the recipient is a member of a commercial HMO, one of the following must be indicated, ***if applicable****:*

Code	Description
OI-P	PAID by HMO. The amount paid is indicated on the claim.
OI-H	HMO does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use OI-H if the commercial HMO denied payment because an otherwise covered service was not provided by a designated or network provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

Element 10 — Is Patient's Condition Related to (not required)

Element 11 — Insured's Policy, Group, or FECA Number

Use the ***first*** box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Bill Medicare before billing Wisconsin Medicaid.

Element 11 should be left blank when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- The recipient's Wisconsin Medicaid file shows he or she does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A. Services related to a diagnosis of chronic renal failure are the only exceptions.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits (EOMB), but do not indicate on the claim form the amount Medicare paid.

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If none of the previous statements are true, a Medicare disclaimer code is necessary.

The following Medicare disclaimer codes can be used when appropriate:

Code	Description
M-1	**Medicare benefits exhausted.** This code can be used when Medicare has denied the charges because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use the M-1 disclaimer in these two instances only: *For Medicare Part A* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. • The recipient is eligible for Medicare Part A. • The service provided is covered by Medicare Part A but is not payable due to benefits being exhausted. *For Medicare Part B* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. • The recipient is eligible for Medicare Part B. • The service provided is covered by Medicare Part B but is not payable due to benefits being exhausted.
M-5	**Provider is not Medicare certified.** *(This code is not applicable to physicians)* This code can be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for DOS before or after their Medicare certification effective dates. Use M-5 in these two instances only: *For Medicare Part A* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A but not for the date the service was provided. • The recipient is eligible for Medicare Part A. • The procedure provided is covered by Medicare Part A. *For Medicare Part B* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B but not for the date the service was provided. • The recipient is eligible for Medicare Part B. • The procedure provided is covered by Medicare Part B.

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M-6 **Recipient not Medicare eligible.** This code can be used when Medicare denies payment for services related to ***chronic renal failure*** (diagnosis code "585") because the recipient is not eligible for Medicare. Medicare must be billed first, even when the recipient is identified in Wisconsin Medicaid files as not eligible for Medicare. Use the M-6 disclaimer code in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

For Medicare Part B (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

M-7 **Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy, not billing errors. Use M-7 in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, etc.

For Medicare Part B (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, etc.

M-8 **Noncovered Medicare service.** This code can be used when Medicare was not billed because the service, under certain circumstances related to the recipient's diagnosis, is not covered. Use M-8 in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is usually covered by Medicare Part A but not under certain circumstances related to the recipient's diagnosis.

For Medicare Part B (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is usually covered by Medicare Part B but not under certain circumstances related to the recipient's diagnosis.

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Elements 12 and 13 — Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source (not required)

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use

If a provider bills an unlisted (or not otherwise specified) procedure code, a description of the procedure must be given in this element. If Element 19 does not provide enough space for the procedure description, or if a provider is billing multiple unlisted procedure codes, documentation must be attached to the claim describing the procedure(s). In this instance, indicate "See Attachment" in Element 19. Unlisted procedure codes are required to be submitted through paper claims submission. Do not bill unlisted procedure codes through electronic billing.

Element 20 — Outside Lab?

If a laboratory handling fee is billed, check "yes" to indicate that the specimen was sent to an outside lab. Otherwise this element is not required.

Element 21 — Diagnosis or Nature of Illness or Injury

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. Wisconsin Medicaid denies claims without the appropriate ICD-9-CM diagnosis code. The diagnosis description is not required.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number

Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Request Form (PA/RF). Services authorized under multiple PA requests must be billed on separate claim forms with their respective PA numbers. No other information should be included in this element (e.g., Clinical Laboratory Improvement Amendment number) or the claim will be denied.

Element 24A — Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one DOS, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field, and subsequent DOS in the "To" field by listing ***only*** the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four DOS per line if one or all of the following is applicable:

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same type of service (TOS) code.
- All procedures have the same place of service (POS) code.

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- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge ***per detail line*** in Element 24F.)
- The number of services performed on each DOS is identical.
- All procedures have the same HealthCheck or family planning indicator.
- All procedures have the same emergency indicator.

Element 24B — Place of Service

Enter the appropriate Medicaid single-digit POS code for each service. See Appendix 2 of this section for a list of POS codes.

Element 24C — Type of Service

Enter the appropriate Medicaid single-digit TOS code for each service. Refer to Appendix 1 of this section for appropriate procedure/TOS code combinations. See Appendix 2 for a list of TOS codes.

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character *Current Procedural Terminology* (CPT) code, Health Care Procedure Coding System (HCPCS), formerly HCFA Common Procedure Coding System code, or local procedure code. Claims received without an appropriate CPT, HCPCS, or local procedure code are denied by Wisconsin Medicaid.

Modifiers

Enter the appropriate two-character modifier in the "Modifier" column of Element 24D, if appropriate. Medicaid-allowable modifiers include:

Modifier	Definition
50	Bilateral Procedure
PD	Pediatric Patient (18 years of age and under)
HP	Health Personnel Shortage Area/Adult (over 18 years of age on DOS)
HK	Health Personnel Shortage Area/Child (18 years of age or under on DOS)

Note: Wisconsin Medicaid has ***not*** adopted all CPT, HCPCS, or Medicare modifiers.

Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis code listed in Element 21.

Element 24F — $ Charges

Enter the total charge for each line item.

Element 24G — Days or Units

Enter the appropriate number of units, time units, qualifying circumstance units, or other services billed for each line item. Always use a decimal (e.g., 2.0 units).

Element 24H — EPSDT/Family Plan

Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. Enter an "F" for each family planning procedure. Enter a "B" if ***both*** HealthCheck and family planning services were provided. If HealthCheck or family planning do not apply, leave this element blank.

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Element 24I — EMG
Enter an "E" for ***each*** procedure performed as an emergency, regardless of the POS. If the procedure is not an emergency, leave this element blank.

Element 24J — COB (not required)

Element 24K — Reserved for Local Use
Enter the eight-digit Medicaid provider number of the performing provider ***for each procedure*** if the billing provider indicated in Element 33 belongs to a physician clinic or group.

Any other information entered in this element may cause claim denial.

Element 25 — Federal Tax I.D. Number (not required)

Element 26 — Patient's Account No.
Optional — provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report.

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge
Enter the total charges for this claim.

Element 29 — Amount Paid
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in this element, "OI-P" must be indicated in Element 9.) Do ***not*** enter Medicare-paid amounts in this field.

Element 30 — Balance Due
Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28.

Element 31 — Signature of Physician or Supplier
The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 32 — Name and Address of Facility Where Services Were Rendered (not required)

Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone
Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number. (Physician assistants are not reimbursable as a billing provider.)